

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024541

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3287

STATE FILE NUMBER

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| VS 300 Rev. 4/59 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT |
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| USE BLACK INK OR TYPEWRITER RIBBON | ITEM NO. | SHOULD READ | BY AFFIDAVIT OF | |

| | | | |
|--|---|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | c. CITY OR TOWN Kansas City | |
| Length of stay in 1b 31 yrs. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp. | | d. STREET ADDRESS (If outside, give location) 8421 Wayne | |
| 3. NAME OF DECEASED (Type or print) First Stella Middle M Last Petro | | 4. DATE OF DEATH Month June Day 9 Year 1963 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5-16-1905 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 9. AGE (last birthday) 58 |
| 11a. FATHER'S NAME Obid D. Noland | | 11b. MOTHER'S MAIDEN NAME Belle Holderman | |
| 12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 12b. SOCIAL SECURITY NO. none | |
| 13a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Carcinoma of Breast DUE TO (b) Carcinoma of Breast DUE TO (c) none | | 13b. INTERVAL BETWEEN ONSET AND DEATH one year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none | | PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE |
| 21. I attended the deceased from 6-2-58 to 6-9-63 and last saw her alive on 6-9-63 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE William R. Doherty MD | | 22b. ADDRESS 2108 W. 75th Prairie View, Kan. | |
| 22c. DATE SIGNED 6-10-63 | | 22d. LOCATION (City, town, or county) (State) Kansas City, Missouri | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 6-11-1963 | |
| 23c. NAME OF CEMETERY OR CREMATORY Floral Hills | | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | |
| 24. FUNERAL DIRECTOR Floral Hills Funeral Home | | 25. DATE RECD. BY LOCAL REG. 6-10-63 | |
| 26. REGISTRAR'S SIGNATURE Ruth H. Long | | 26. REGISTRAR'S SIGNATURE | |

(Licensed Embalmer's Statement on Reverse Side)

Dr. Wm. R. DeLoach
2108 W. 7th St
En 2-2900
The 1-5 PM

Dr. Robert T. DeLoach + M. B.
The 1-5 PM
344000 B. DeLoach
2-5 PM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed C. M. Joerner
Licensed Embalmer No. 3453

P. O. Address H. E. Kane

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.